# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

Do not use this space.

16598

**1. PLACE OF DEATH**

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1002 Registered No. 5121

City St. Louis (No. City Hospital St. ..... Ward)

1711

**2. FULL NAME** Charles Henderson Jr.

(a) Residence. No. 5285 Washington Ward. 12
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
|---|---|---|
| male | white | single |

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 6-1931

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | | 1 | 23 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work nil
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Chas. Henderson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Lorene Pollitt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo.

14. INFORMANT Hospital Information Grace Kopp
(Address) City Hospital

15. FILED ..... 19 ..... Max C Starkey REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 29th -31

17. I HEREBY CERTIFY, That I attended deceased from April 28th, 1931, to April 29th, 1931, that I last saw him alive on April 29th, 1931, and that death occurred, on the date stated above, at 6.20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemorrhagic disease of the newborn

1610 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 1610 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & autopsy

(Signed) V E Scherman, M. D.

4/29, 1931 (Address) City Hosp.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL |
|---|---|
| Flat River Mo | 4/30 1931 |

| 20. UNDERTAKER | ADDRESS |
|---|---|
| Hood Und. | Flat River Mo |

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

[illegible] WITH OR ADDING INK—THIS IS A PERMANENT RECORD